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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Strangulated Hernia. Delivered at the London Hospital. By C. F. MAUNDER, F.R.C.S., Surgeon to the Hospital.

GENTLEMEN: By a curious coincidence a case of strangulated hernia has come under my care on the last day of each of my last three in-taking weeks. Each case has some special points of interest.

Case 1.—This was an instance of strangulated inguinal hernia of the left side, reduced *en masse* by the patient himself. I operated upon him successfully; and for the second time, with an interval of ten years.

Case 2. *Femoral hernia; operation; recovery.* (Reported by Mr. Herman Tribe.)—H. MacC—, aged fifty-eight, a blacksmith, was admitted on June 20th, 1876. Ten months ago he observed a swelling in his left groin, which sometimes disappeared. On June 17th the swelling became very hard and painful, and vomiting, which has persisted, set in. On examination to-day (June 20th) a hard, globular tumour was found at the seat of femoral hernia. There was slight impulse on coughing(?). The finger could easily be passed into the inguinal canal. The patient still vomited, appeared to be very weak, and his countenance looked haggard. An operation was considered advisable, and the man at once consented.

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The taxis was not employed by Mr. Maunder, but he opened the sac, which proved to be very thin, at once. A small quantity of turbid fluid escaped. The knuckle of intestine was portwine-coloured, slightly roughened with lymph. A very tight stricture was nicked, and the bowel reduced. The wound having been closed with suture, and a compress and bandage applied, the patient was returned to bed, and a grain of opium administered. Milk diet.

June 21st. He complains of slight pain in the abdomen, but of no tenderness. Temperature 101.5°; pulse 102. To take a grain of opium every six hours. 22d. Has slept well. There is a little redness and swelling about the wound. Lest decomposing fluids should be pent up, the sutures were removed, and the margins of the incision forcibly separated. A poultice to be applied. 23d. The redness about the wound has disappeared. The bowels are somewhat relaxed. The appetite is returning. Temperature 99.6°; pulse 96. 25th. The patient has suffered from diarrhoea since yesterday. To take chalk mixture. 26th. Diarrhoea has ceased. Wound suppurating freely. Replace the poultice by water-dressing. 27th. Diarrhoea came on again. July 6th. The patient is convalescent; the wound nearly healed. Zinc dressing. 14th. The patient is quite well, and awaits his truss.

Case 3. *Strangulated inguinal hernia; operation; recovery.* (Reported by Mr. Herman Tribe.)—Samuel S—, aged thirty-three, a builder, was admitted July 18th, 1876. Ten years ago, whilst at work, the patient ruptured himself. He had the rupture at once reduced by a surgeon. Since that time he has always been obliged to wear a truss; the hernia has never given him any trouble. On July 17th he neglected to wear his truss, and after he had been at work a little while the hernia came down. The patient attempted to reduce it, but could not do so. In about an hour's time he was compelled to leave work on account of vomiting. He went home to bed, was in great pain all night, and the vomiting persisted.

On examination a left inguino-scrotal

tumour is found, pyriform in shape, tense, and painful. There is marked impulse on coughing (?). The tumour is not compressible. The patient vomits constantly.

Operation, eighteen hours after descent of hernia.—The patient having been placed under the influence of an anæsthetic, the taxis was applied for fifteen minutes, but failed to reduce the swelling. Herniotomy was then done. The structures were successively divided by a longitudinal incision over the neck of the swelling until the sac was reached. In this structure a most marked annular depression was both seen and felt, and proved to be the seat of stricture. This grooved portion of the sac was carefully divided by repeated scratches of the knife. Through the small button-hole thus formed omentum showed; and now, when the taxis was again applied, reduction was effected. The wound was closed in the usual way, and a dose of opium administered.

July 19th. The patient is very comfortable. 20th. Sutures removed. 21st. Bowels spontaneously moved. Slight suppuration with some redness and swelling about the wound, the edges of which Mr. Maunder now forcibly separated. Poultice to be applied. 24th. Redness and swelling have disappeared from the wound. Zinc ointment to be used. Aug. 1st. The patient is quite well, and is only waiting to have a truss.

With regard to Case 1—reduction *en masse*—I shall say nothing to-day, having taken every opportunity of drawing your attention to its importance when the man was in the hospital. It is published in *The Lancet* (July 28th, 1876), and can be referred to by those interested in the subject.

Case 2 is an example of femoral hernia in the male—a lesion of comparatively rare occurrence, though probably less rare than inguinal hernia in the female. Possibly, out of at least 120 herniotomies, some half-dozen of femoral in the male have fallen to my lot. In the present instance the tumour was typical, being globular in shape, seated at the upper and inner side of the base of Scarpa's triangle, whence it could not be displaced to the inner side of the spine of the pubis.

In both Cases 2 and 3 the notes say "there was impulse on coughing." To this I have added a query, as there really was none. It is desirable you should understand, in connection with hernia, the value, as a symptom, of the presence or absence of "impulse on coughing." Supposing the sac to contain bowel, with impulse on coughing, that would be proof that the contents of the intestine, both above and below the point of protrusion, directly communicated, and strangulation would not exist. The absence of impulse would show an absence of intercommunication, and that stricture existed. To avoid error, then, with regard to the presence or absence of impulse, the hernial tumour must be lifted away from the abdominal wall, when the *propulsion*—sometimes mistaken for impulse—communicated on coughing will be no longer felt, and the question of impulse settled. Imagine a patient with a hernia on either side and symptoms of strangulation. The absence of impulse on the one side and its existence on the other would materially help you to decide which to select for exploration. This method of examining a hernial tumour will prevent a very usual mistake. The local tumour and persistent vomiting in both instances led to the conclusion that we had a case of strangulated hernia to deal with, and reduction became the first consideration. This may be effected by the taxis, with or without the aid of the knife.

Question of taxis.—The taxis, a most valuable agent when judiciously applied, may, under some circumstances, be most injurious. You will have observed that I did not employ it in Case 2, but resorted to it for a quarter of an hour in Case 3. Observe the history of the two patients before they came under care. Case 2 had a history of strangulation extending over three days and three nights, and had only been ruptured ten months. Case 3, on the contrary, had been ruptured ten years, and his present symptoms extended over eighteen hours only. As a rule, the longer a person has been ruptured the larger becomes the ring, and the less quickly injurious will be its effect upon the structures which it constricts; and

therefore, for the above reasons, I proceeded at once with herniotomy in Case 2, feeling pretty confident that I should not effect reduction, and that I ought to see the condition of the intestine before reducing it. With Case 3, whose hernial history was quite the reverse of Case 2, I fully expected to effect reduction by the taxis, but failed. The unyielding neck of the sac, exposed by the operation, explained the reason. Speaking generally of the taxis, I say: Use it thoroughly once only, aided by an anæsthetic if admissible, or other adjuvant: should it fail, resort to herniotomy. Even a successful taxis cannot but bruise, and that to a dangerous degree, an already much inflamed portion of bowel. This often efficient remedy can be aided by position, the trunk and limb of the patient being so placed as to favour relaxation of all the structures interested at the hernial aperture. As an illustration, I may mention that many years ago a male, the subject of femoral hernia, was under my care among the out-patients. When the patient was recumbent, and his lower extremity, of the side on which the hernia was, extended, moderate taxis failed to effect reduction; but with the thigh flexed, adducted, and rotated inwards, reduction was easy. Doubtless this facility was due to a relaxation of the upper cornu of the saphenous opening of the fascia lata.

Question of opening the sac.—This used to be a much-vexed question, but I fancy surgeons are pretty well agreed that in femoral hernia it is almost immaterial whether the sac be opened or not. Personally I avoid doing so, except under special circumstances, on the good general principle of non-interference. But in the case of an inguino-scrotal hernia I am most reluctant to open it. You will recollect how I pointed out to you the probable position of the stricture in the case of No. 3, and which coincided with the external ring. This I nicked and enlarged, but even then could not effect reduction, and it was only when I reached the sac and showed to you a deep sulcus in this that the immediate obstacle was evident. Mr. Tribe has described the care and caution which I used, and the very small

wound which I made in the serous membrane, with a view to enlarge the constricting neck just enough to admit of reduction. I allowed nothing—not even the point of a director, much less my finger—to enter the sac, so as to avoid every risk of peritonitis.

The after-treatment of the wound requires some consideration. I generally close it with the hope of getting primary union, and now and then this has resulted both in hospital and in private practice. But the surgeon must be on his guard, the parts being concealed by compress and bandage, lest decomposing fluids become pent up and give rise to both local and constitutional disturbance. Should one or both arise, as occurred in these cases, the treatment is evident. Some years ago a man of seventy, from Chigwell, had been submitted to herniotomy. He progressed very favourably for several days, when, finding him drowsy and somewhat light-headed, with loss of appetite, I examined the seat of the wound, which, though healed, fluctuated. I opened it up, and gave exit to some stinking pus. A charcoal poultice was applied. On the next day all unfavourable symptoms had vanished, and the patient recovered.

Of these three patients two suffered a good deal from diarrhoea. It is reasonable to suppose that a portion of intestine injured by compression and inflammatory action would take time to recover its health. To give it rest that it may do so, we generally administer one or more doses of opium to arrest peristalsis, and administer liquid nourishment for a few days. Possibly a subacute enteritis, spreading from the damaged portion of bowel, may account for this relaxed condition. This might be prevented by a method of treatment which commends itself to my judgment, recently suggested by Mr. De Berdt Hovell. It consists in supporting the patient by nutrient enemata for a few days subsequent to operation. Certainly, by this method the small intestines would be left quiescent, and possible perforation be averted.

Your patient must not get up until provided with a suitable truss. No patient who is ruptured should be without his

truss, except when he is recumbent. The danger of going without it is illustrated by Case 3. For ten years the man had not been without it, and the hernia had never given him any trouble. He omits to wear it, and becomes the subject of strangulation and herniotomy.—*Lancet*, Jan. 13, 1877.

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Cases of Paralysis of the Musculo-Spiral Nerve. By Wm. R. GOWERS, M.D., Assist. Phys. to University Hospital, London.

Paralysis of the musculo-spiral nerve is of not very rare occurrence, but it is of interest from the illustration it affords of the consequences of certain forms of nerve-injury. The following cases treated at the National Hospital for the Paralyzed and Epileptic illustrate some points of practical importance in the symptomatology of the affection:—

Case 1. Paralysis of Musculo-Spiral Nerve from Pressure; Electrical Contractility of Muscles unchanged; Rapid Recovery.—A porter, aged forty-two, presented himself on January 5 with complete paralysis of the extensors of the wrist and long extensors of the fingers, of one month's duration. He had gone to sleep when lying on a bench on his right side, and woke up unable to extend the hand. Three years before, when at sea, he had had a similar attack from a similar cause, but the paralysis on that occasion lasted only three days. When first seen no improvement had occurred. No extension of the wrist or metacarpo-phalangeal joints was possible. If the proximal phalanges, however, were passively extended, the two distal joints could be readily extended by the interossei, which were unaffected. He complained of tingling in that part of the hand which is supplied by the radial division of the musculo-spiral, but no loss of sensibility could be detected. Electrical examination showed that although there was complete paralysis, there was no loss of contractility to the faradic current in any muscle except in the extensor ossis metacarpi pollicis, which did not act quite so readily as on the other side. There was no increase in contractility to the voltaic current. He was ordered faradisation of the affected

muscles, and the voltaic current along the course of the nerve every other day. In a week he had recovered considerable power of extension, and the slight defect in the irritability of the extensor of the thumb could no longer be detected; and in another week he was so rapidly improving that he ceased to attend.

Case 2. Paralysis of the Musculo-Spiral Nerve from Pressure; Change in Electrical Contractility of Muscles; Slow Recovery.—

A man, aged fifty-three, in the beginning of September, 1876, went to sleep with his arm over a sharp piece of wood, with the elbow bent. On waking he found the whole arm numb and tingling, and that he could not extend the wrist or fingers. He came to the hospital a month later, and it was then found that there was complete loss of power in all the muscles supplied by the musculo-spiral nerve, and in no others. There was marked flattening of the back of the forearm. Electrical investigation showed that, compared with the left arm, there was considerable diminution of contractility to faradism in the radial extensor of the wrist, and a slighter but distinct diminution in the ulnar extensor of the wrist and common extensor of the fingers. There was no loss of irritability in the supinator longus, but considerable diminution in the force of its contraction; a current of moderate strength caused a much stronger contraction in the supinator longus on the healthy than on the affected side. There was no loss of contractility in the lower part of the triceps, the hand muscles, or the muscles on the flexor aspect of the forearm. The muscles in which the faradic contractility was lessened presented a distinct increase in their irritability to the voltaic current. Faradisation of the affected muscles was ordered, and in a fortnight, although there was no return of voluntary power, the faradic contractility had so far returned that scarcely any difference could be detected between the muscles of the two arms, and the increased irritability to the voltaic current had disappeared. The same treatment was continued, and the improvement in contractility was soon followed by a return of voluntary power, which increased

so that by the beginning of January the wrist and fingers could be extended as completely as on the other side. Both the extensors and supinators were weak, however, so that if he raised a weight from the table with the hand midway between pronation and supination, there was a tendency to increased pronation. The weakness of the extensors was shown also indirectly by the defective strength of grasp, which in the right hand was only twelve kilogrammes, while in the left it was thirty-five. The treatment was continued, however, and in another two months the arm was affirmed by the patient (and appeared) to be perfectly well.

Remarks.—The musculo-spiral nerve is of all nerves of the arm that most frequently paralyzed. This is the result of its exposed course as it winds round the humerus beneath the triceps muscle. This position exposes it to two dangers: to the effects of pressure, and to the damage in violent contractions of the triceps. The first of these is the more common, and is illustrated by the cases detailed. The position of the nerve protects it to some extent from sudden violence, but exposes it to damage from long-continued pressure, as in certain postures not unfrequently assumed during sleep. Occasionally, although rarely, paralysis results from pressure during sleep in bed. The patient goes to sleep on the right side with the arm under him, and wakes in the morning with the extensors of the wrist paralyzed. The more common cause is an afternoon nap on a chair or a bench, with the arm hanging over some hard or sharp edge. It is curious that one patient should have had two attacks produced in this way. This may have been due to some habitual position of the arm during sleep, or to the musculo-spiral nerve having a course more than usually exposed. The other way in which the nerve sometimes gets injured is by a violent muscular contraction. Dr. Gowers has seen two cases in which this occurred. One patient was an epileptic liable to attacks of *petit mal*. He felt an attack coming on, and to save himself from falling, seized a rain-water pipe

close to which he was standing. On recovering consciousness he found himself still grasping the pipe, and had some difficulty in relaxing his hold, in consequence of complete loss of power over the extensors of the hand. There was at first general weakness of the limb, but it soon became limited to the muscles supplied by the musculo-spiral nerve. These rapidly wasted and presented the loss of faradic and increase of voltaic contractility. In another case the same accident happened during a violent extension of the arm in throwing a stone. There was instantly violent pain in the arm, and complete paralysis of the extensors of the wrist and fingers. A few days afterwards extravasations of blood were apparent along the edge of the biceps and also at the back over the triceps muscle. It is probable that laceration of some of the muscular fibres caused an extensive hemorrhage. In this case, a month after the injury, the faradic contractility was lost in all the muscles of the forearm supplied by the musculo-spiral nerve, and also in the lower part of the triceps muscle. The weakness of the flexors, which is conspicuous in all cases of extensor paralysis, and which was very marked in those above described, is, of course, apparent only. The flexors of the fingers, acting on both wrist and digits, can only act on the latter with force if the wrist is kept extended. Flexion of the wrist shortens so much the course of the flexor tendons that only very slight flexion of the fingers is possible. This is easily shown in the healthy. If the wrist-joint be forcibly flexed, the two distal joints of the fingers can be flexed only very slightly, and at the expense of much pain in the flexor muscles in the forearm. The constant carpal flexion on use of the hand in these cases of extensor paralysis often causes a slight backward protrusion of the carpal bones, which is the source of much uneasiness to the patient.

These cases illustrate the prognostic as well as the diagnostic value of the electrical examination of paralyzed muscles. The change in faradic contractility is an index to the state of nutrition of the nerve-fibres both within and without the

muscle. The profound diminution in the faradic contractility indicates, as is well known, a degenerated state of the nerve-fibres, the result of an irritating lesion of the nerve at the seat of injury. To this the electrical contractility is the only sure guide. Visible loss of nutrition in the muscles is a less certain indication, since the flabbiness of atony may be mistaken for the shrinking of atrophy. Loss of muscular power is no guide as to the state of the nerves and muscles, as these cases show. Each came under observation a month after the injury. In each when first seen the loss of power was complete; but the first, in which there was no evidence of nerve-degeneration, was well in a few weeks; the second, in which there was marked depression of faradic contractility, was well only in a few months; while in the case of the epileptic, in whose muscles the depression of faradic contractility was profound, nine months passed before there was any return of power, although he also ultimately made a good recovery. Another point in regard to the contractility of paralyzed muscles was illustrated by Case 2. The supinator longus presented no loss of irritability; slight contraction occurred to a current of the same strength as was needed for the healthy muscle, but a stronger current caused far less contraction in the paralyzed than in the unaffected muscle. In testing a muscle the most significant thing to note is the contractility—the weakest current to which it will react; but it is also important to note the power of the muscle—the degree of contraction to a stronger current—since the latter may, in rare cases, be altered, as a consequence of nerve-injury, etc., while the former remains normal. It is impossible to doubt the usefulness of electrical applications in such cases. No doubt the slighter cases would recover without its aid, but it is frequently to be noted that the first return of power occurs soon after the commencement of electrical treatment. The excitation of the nerve seems to aid the recovery of a state in which the voluntary stimulus can traverse the fibres. For this purpose, in the case of the musculo-spiral

nerve, the voltaic current is most effective on account of the deep course of the nerve beneath the fibres of the triceps muscle, and the voltaic current has much greater power of penetrating a layer of muscular fibre than the faradic. The latter is, as it were, absorbed by the contracting muscular fibres to a far greater extent than the voltaic current. In more severe cases, as in that of the epileptic mentioned, in which all nerve-irritability for a time is lost, the application of the voltaic current to the muscles is often followed by an improvement in their nutrition. In that patient this was very marked, and voluntary power was ultimately regained, although it had been absent for many months, during which the muscles distinctly improved in size under the treatment.—*Med. Times and Gaz.*, May 5, 1877.

HOSPITAL NOTES AND GLEANINGS.

A Case of Placenta Prævia; Narrow Escape from Asphyxia under Chloroform; Intra-uterine Respiration of the Fœtus.—The fact of the establishment of intra-uterine respiration in the subjoined case, which came under Dr. Galabin's care at the Guy's Hospital Lying-in Charity, has an important medico-legal as well as a clinical bearing. Post-mortem examination showed that the left lung had been sufficiently expanded by air to float in water, although the fœtus had probably died at least three hours before delivery.

For the following notes we are indebted to Mr. J. BRETT, M.R.C.S., resident obstetric assistant.

On the afternoon of Feb. 12, 1877, a woman twenty-five years of age, between the seventh and eighth months of her fourth pregnancy, sent for assistance. Two weeks before she had had a fall on the left side, and the day previous she had received a blow upon the abdomen. All the morning she had been exerting herself in lifting weights, when suddenly, at 1.30 P. M., she felt a sudden gush from the vagina. At least two pints of blood were lost at this time, and the bleeding continued in lesser quantity. None had occurred previously during her preg-

nancy. The woman fainted from loss of blood, and was lifted into bed. When first seen she had a pulse of 130, extremely weak. No labour-pains had commenced; the os was sufficiently dilated to admit one finger; and the edge of the placenta was felt partially occupying the cervical canal. Dr. Galabin was sent for, but was not at home. The membranes were then ruptured, ergot administered, and a watch kept upon the patient. Her condition appeared so hazardous that all preparations were made for transfusion, in the expectation that this operation might become necessary before delivery could be effected.

Dr. Galabin visited the patient at 7 P. M. She had then somewhat revived, but was extremely blanched, and no uterine contractions whatever had occurred. The cervix was very rigid, and at least three inches long; the internal os was dilated enough to admit two fingers, and the external os was somewhat wider. The vertex was presenting, but was very high up, being displaced by the placenta. The placenta was still attached posteriorly up to the margin of the internal os. It was separated by the finger from the lower segment of the uterus for about two inches, according to the method recommended by Dr. Barnes, but, the uterus being perfectly flaccid, the hemorrhage was not diminished by this means, but rather increased, and the vagina repeatedly became filled with clots. It was then proposed to introduce a hydrostatic dilator into the cervix, but the patient, who was extremely restless and unmanageable, refused to allow any such manipulation without the use of chloroform. In order, therefore, to avoid more than a single administration—since an anæsthetic appeared hazardous in the patient's anæmic state—it was resolved to perform version if possible. The pulse becoming almost imperceptible before the patient was fully under chloroform, the anæsthetic was changed to ether. She then made a slight effort at vomiting, and was quickly observed to be choking. The jaws were tightly clenched, and could not be forced open till she was apparently dead. The larynx was then cleared by

the finger from some vomited matter which obstructed it, and artificial respiration was performed for some minutes, after which natural breathing was restored.

Bipolar version was then performed by Dr. Gnablin, the patient being in the dorsal position, and the right hand used internally. The head was already so high that its upper margin was at the level of the umbilicus, and could not be pushed much farther by the internal fingers passed through the elongated cervix; it was therefore carried up to the right iliac region by the external hand acting alone, and the left knee was afterwards pushed down within reach of the finger in the cervix. Bleeding was arrested from this time, but the cervix remained too rigid to allow delivery to be completed, although ergot was again administered, and traction made upon the leg. The fœtus was then observed to make convulsive movements, and with each movement a gasping sound was heard from the uterus; this was audible at the other extremity of the small room, and upon auscultation had a startling loudness. It was evident that during version air had found its way to the fundus of the uterus, and that the fœtus, becoming asphyxiated from detachment of the placenta, was trying to breathe. The gasping was continued at intervals for about a quarter of an hour. It was impossible to effect extraction quickly, and no attempt was made to supply the fœtus with air through a tube for fear it should obtain entry into the uterine veins. If a double-action canula had been at hand, it might have been a safe measure to withdraw air by suction through it from the uterus, thus allowing fresh air to supply its place, and keep the fœtus alive until the cervix yielded. About three hours afterwards some uterine contraction commenced, four full doses of ergot having been given. The cervix gradually dilated, strong traction being made upon both legs, and the fœtus was extracted about four hours after the performance of version; it gave no sign of life. An autopsy was made, and it was evident that air had entered the lungs, the greater part of the left lung

being sufficiently expanded to float in water. The fact of the intra-uterine respiration of air was thus confirmed. The mother suffered from severe febrile symptoms from the second to the fourth day, the temperature rising to 105°, and the pulse to 140; but eventually she made a good recovery.—*Lancet*, April 21, 1877.

Removal of Naso-pharyngeal Polypus.—

M. VERNEUIL, of La Pitié Hospital, lately removed from a boy, aged eight years, a large naso-pharyngeal polypus. The operation was attended with considerable hemorrhage; and, in consequence, symptoms of acute anæmia set in; and in the evening of the day of the operation, about four hours afterwards, the boy was so low—the temperature of the body having fallen to 33½ deg. Cent. (92.3 Fahr.)—that the *interne* on duty summoned M. Verneuil to see the patient. M. Verneuil not being at home, it was determined to keep the patient up by administering stimulants, such as brandy and water, pure claret, etc., which had the effect of producing a slight rise of the temperature. At 8 P. M., M. Verneuil, finding the patient still extremely low, at once injected hypodermically ten drops of sulphuric ether, and in about half an hour afterwards repeated the injection. From this time forward, the temperature gradually rose, and about forty hours after the operation was found to be a little above the normal standard. This case elicited some instructive remarks in a clinical lecture from M. Verneuil. In referring to syncope in connection with great operations he said that this state may occur before, during, or after an operation. In the first case, it may be brought on by simple fright, as in the celebrated case of lithotomy related by Desault, in which whilst he was describing the operation to his audience, and delineating on the patient the different steps of the operation, the latter suddenly died on the operating-table before any incision was made. Syncope during and after an operation may arise from nervous shock or from profuse hemorrhage. It sometimes happens that instead of taking place during or immedi-

ately after an operation, it may supervene some hours afterwards, which fact would point to the necessity of constant watching and nursing of the patient until he is considered out of danger. Among the remedial agents for this grave condition of syncope, transfusion has been somewhat extensively employed; but M. Verneuil is not at all partial to it under any circumstances. Indeed, he looks upon it as a most dangerous remedy, as the blood, whether of man or of animals, being of a highly putrescible character, would, even when immediate transfusion is practised, be liable to produce septicæmia, or even pyæmia. He took occasion to say that, whenever transfusion is indicated, as in syncope or excessive hemorrhage, the hypodermic injection of ether or ammonia would be preferable to transfusion of blood or any other liquid, even in puerperal or post-partum hemorrhage.—*British Med. Journal*, March 31, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Administration of Cod-Liver Oil in Malt Extract.—At a recent meeting of the Norfolk District Medical Society, Prof. MANKOW (*Boston Med. and Surg. Journ.*, May 3, 1877) called attention to malt extract as an emulsive agent for cod-liver oils and other oleaginous preparations. At the present time, when cod-liver oil is extensively employed as a therapeutic agent, anything that will neutralize or overcome its disagreeable oily character and bad taste will be welcomed by patients. Extract of malt possesses the power of producing a perfect emulsion with cod-liver oil, and a mixture of equal parts of cod-liver oil and extract of malt was exhibited, having a semi-solid consistence, in which the taste of the cod-liver oil was more perfectly concealed than can be accomplished by any other known process. Other mixtures were also shown containing various proportions of cod-liver oil, and to which various flavoring extracts had been added.

Death during Etherization.—Dr. BENJAMIN W. ROBINSON, of Fayetteville, N. C.,

reports (*Virginia Med. Monthly*, April, 1877) the case of Mrs. McNeil, who consulted him on account of a tumour of the breast, which he extirpated while the patient was under the influence of ether. The tumour returned, and the operation was repeated in ten months. Again after the lapse of six months, a third operation was performed, and Squibb's ether was administered in a conical inhaler. During the inhalation the pulse improved in volume and force. In about twenty minutes after the operation was begun, it was announced that, with gradually increasing pallour, the radial and temporal pulse, which had been failing since the operation began, were extinct, and that the respiration was irregular. Brandy was administered subcutaneously, the foot of the operating table raised, and artificial respiration practised. The lapse of a few minutes promised thorough resuscitation, the patient became conscious, the horizontal posture was restored, and the operation was continued without the inhalation of any more ether. In a few minutes the patient vomited, after which it was found that she was sinking. All efforts at resuscitation now proved unavailing. A post-mortem examination appears not to have been made, but the history of the case leads to the suspicion that death was caused by the trachea becoming choked up with vomited matter.

Deaths from Chloroform.—Dr. CHARLES ANDERSON records (*Clinic*, March 31, 1877) over twenty cases of death from chloroform which have occurred in Cincinnati and its vicinity within the last thirty years. Some of these were not previously recorded.

In the *American Journal of Dental Science*, May, 1877, is reported the death of Dr. Chas. A. Jourdan, caused by the inhalation of chloroform prior to the extirpation of his eye.

The American Medical Association.—The meetings of the Association for some years past, even its most ardent supporters must admit, have not produced the results which should follow from the gathering together of so many able and practical members of

the profession. The late International Medical Congress has demonstrated what can be done with the same material, for the most part, under a good plan of organization, with an intelligent arrangement of details, and we trust that the example which it gave will not be lost upon the Association.

We have not seen the programme prepared by the Committee of Arrangements for the ensuing meeting, but trust that it embraces as many as possible of those elements which did much to insure the pre-eminent success of the late Congress at Philadelphia. Judging from the experience of last September, we think every delegate will agree with us in saying that it is very desirable that a detailed programme be published in advance of the meeting, giving the work for each day and hour; that all the Sections meet under the same roof; that a lunch be provided in the building where the meeting is held, so that the members may be kept together the entire day; that a list of delegates registered up to date be published daily; and that the social aspect of the meeting, although an important feature, be kept strictly subsidiary to the scientific work.

At this session of the Association we hope a plan for the future will be devised by which the scientific character of the meetings may be promoted hereafter, and their value enhanced. As tending to the accomplishment of such an aim we would suggest that the general meetings should be solely devoted to the reading of the addresses already provided for, to the reception and action upon the reports from the various Sections communicating the results of their scientific labours, and to such business as may be brought before the Association by the Judicial Council, to which Council all motions relating to private business should be first referred without debate. The meetings of the Sections should be devoted to the consideration of scientific subjects determined upon beforehand, the discussion of which would be opened by reporters, and outlines of whose remarks should be published at least three months in advance of the meeting, so as to promote intelligent debate. The conclusions

of the Sections upon the topics discussed could be ascertained by vote, and reported to the Association in general meeting. Provision ought also to be made for the reading and discussion of volunteer papers.

Such changes as are above indicated would, we think, undoubtedly result greatly to the advantage of the Association.

The Association and the Pharmacopœia.

—In an able paper read before the Philadelphia College of Pharmacy (*American Journal of Pharmacy*, May, 1877), Mr. Alfred B. Taylor discusses Dr. Squibb's propositions for the seizure by the American Medical Association of the Pharmacopœia of the United States; and he particularly calls attention to that part of the plan for the future revision of the Pharmacopœia, which in Dr. Squibb's opinion is to insure to it a thoroughly national character. "The plan which is to be submitted to the American Medical Association, at its meeting in June next, is that it shall organize a Pharmacopœial Council, to be incorporated if necessary, consisting of five members, which council shall be charged with the entire management of the Pharmacopœia and all that pertains to it, and be responsible only to the American Medical Association. This council I would propose to form as follows: The nominating committee of the Association to nominate and the Association to elect the president of the council; then the Association to invite the surgeon-generals of the army and navy each to appoint one member, and invite the American Pharmaceutical Association to appoint two members." (Dr. Squibb's pamphlet, p. 25.) Now for the *modus operandi*. "As the meetings of this council would have to be frequent during the general revisions, and perhaps two or three times a year for the supplementary fasciculi, and as the members would have to educate themselves to the special work, it would, perhaps, be better that the council should be small and compact, and live in adjacent cities." (*Ibid.* p. 9.) As three of the council are to constitute a *quorum* (*Ibid.* p. 64), who may "obtain a change

in any of its members," we should probably have, as the final outcome of the so-much-vaunted "nationality" of the enterprise, a pharmacopœia under the entire control of *three representatives of the United States* (small and compact), "living in immediately adjacent cities!" And this is gravely proposed as an eminently "national" improvement on the existing *local* plan of an executive committee of *fifteen*, representing *nine* leading cities, from Boston to Richmond, and from New York to San Francisco, together with a representative of the army and of the navy of the United States.

At a recent special meeting of the Philadelphia County Medical Society held to consider Dr. Squibb's proposition, Dr. Albert H. Smith presented the following resolutions, which were unanimously adopted:—

Resolved, That this Society does not recognize the legal or moral right of the American Medical Association to assume the work of issuing a Pharmacopœia as proposed, nor its fitness for the work, if such right existed.

Resolved, That its delegates to the American Medical Association be instructed to use every proper means, by their votes and influence, to prevent the consummation of the plan proposed by Dr. Squibb.

The following resolutions, offered by Dr. Nebinger, were also adopted:—

Resolved, That in the opinion of the Philadelphia County Medical Society, the propositions of Dr. Squibb to modify the period of revision of the United States Pharmacopœia and other proposed reforms, are deserving of careful consideration by the medical and pharmaceutical professions.

Resolved, That in the judgment of this Society, such reforms and modifications of ancient plans can be more safely entrusted to the National Convention for the revision of the Pharmacopœia and its committee of revision, than to any new organization.

Resolved, That the action of this Society be officially transmitted to Dr. John C. Riley, President of the Pharmacopœial Convention at Washington, to Dr. Bow-

ditch, President of the American Medical Association at Chicago, and to Dr. Squibb of Brooklyn.

Medical and Chirurgical Faculty of Maryland.—The 79th annual session of this Association was convened at Baltimore, on April 11th, Dr. Christopher Johnson, president, in the chair. The following officers were elected for the ensuing year: President, A. B. Arnold, M.D. Vice Presidents, Drs. S. C. Chew, Ferdinand Chastard, and Charles H. Jones. Secretary, Dr. W. G. Regester.

Mississippi State Medical Association.—The tenth annual meeting was held in Grenada, on April 4th, Dr. P. J. McCormick, president, in the chair. The following officers were elected for the ensuing year: President, Dr. B. A. Vaughan, of Columbus. Vice-Presidents, Dr. E. W. Hughes, of Grenada, T. R. Trotter, of Duck Hill, T. P. Lockwood, of Crystal Springs, and J. T. Parker, of Buena Vista. Secretary, Dr. Wirt Johnson, of Jackson. The next meeting will be held at Jackson, on the third Wednesday in January, 1878.

Texas State Medical Association.—The annual meeting of this Society was held at Galveston on April 3d, Dr. B. H. Harrison, of Columbus, president, in the chair. The following officers were elected for the ensuing year: President, Dr. Kelley, of Galveston; Vice-Presidents, Drs. Cupples, of San Antonio, Swearinger, of Austin, Sayers, of Waco; Treasurer, Dr. Achison, of Denison. The next meeting will be held in San Antonio on the first Tuesday in April, 1878.

Changes in the Regulations of the Medical Department of the University of Pennsylvania.—At a special meeting of the Board of Trustees of the University held on the 15th of May, it was resolved that hereafter all students shall be required to attend three annual courses of lectures of five months each, each course to be so graded as to prepare the student for the studies of the next. At the close of each annual course, examinations on the studies will be held to test the student's fitness to pass on to the next course. The

above arrangement of studies will enable the third year to be devoted chiefly to the study of practical branches, and it is proposed to teach these "in a more thorough way than has ever been done in America." There will be no preliminary examination for admission. The fees will be \$140 for the first and second years each as heretofore, and \$100 for the third year. The above changes will not affect in the least the status of the present matriculants of the school, who can complete their studies and graduate upon the old plan, unless they elect voluntarily to pursue the new course. The professors will hereafter be paid salaries, so as to be independent of the size of the classes.

This system is substituted for the present two-years course of lectures which, as now delivered, are identically the same each year; and it introduces into medical study the system which is pursued in all other forms of study.

To successfully carry out these efforts to give a better education, which has been demanded by the profession in one form or another for the last thirty years, it is needless to say that a large endowment fund is necessary, and for it the Trustees confidently look to the friends of the University. Already a number of the citizens of Philadelphia have liberally come forward and have guaranteed for several years the University against any pecuniary loss which may result from the temporary diminution in the size of the classes which, it is thought, may for a few years follow upon the adoption of the improved curriculum; and we trust that the profession at large will be equally prompt in giving their sympathy and support to this commendable effort to elevate the standard of medical education in this country.

Harvard University.—Dr. John P. Reynolds has been appointed to the Chair of Obstetrics at the Harvard Medical School, left vacant by the death of Dr. Buckingham.

Changes in the Philadelphia Medical Schools.—Dr. Robert E. Rogers has been elected to the Chair of Medical Chemistry

and Jurisprudence in the Jefferson Medical College. Dr. John Neill has resigned the Chair of Clinical Surgery in the University of Pennsylvania.

Maryland Medical Journal.—The first number of this periodical was published at Baltimore on May 1. It is an octavo of 36 pages, under the editorial and business control of Drs. H. E. T. Manning and T. A. Ashby. It contains four original articles, and editorials and selections. In placing it on our exchange list, we cordially wish it all success.

Homes for the Reformation of Intemperate Women.—Various attempts have been made to establish reformatories for drunken women, but heretofore all have failed to accomplish any encouraging results, and a few years have witnessed their closure. The class of cases received has not been permanently impressed, and the one most likely to be reformed has not been induced to submit their cases for treatment. The "snuff-chewing sisterhood" compose about 80 per cent. of the applicants; and experience teaches that their drunkenness is so interwoven with other vices, that it is next to impossible to reform them. But there is a class of cases in all our large cities that ought to be reached, and that might be benefited, but as yet they have not been; we refer to those in the higher walks of life, who by birth, education, and general deportment, are, when sober, recognized as ladies. They have not been reached, for the following reasons, viz.: 1. Female reformatories cannot be conducted as those for men. Publicity is a great obstacle to the former, but a benefit to the latter. 2. Secrecy rules to a large extent in the drinking of women; and the more public it becomes, the less hope is there for reformation, if received into a home. Shame has a great influence, and treatment must be made as free from the eye of the public as possible. 3. A mixed company is rather an advantage in a home for men, but ruinous to success in one for women, as they will not subject themselves to the risks of subsequent forced association or recognition on the part of

objectionable acquaintances made while under treatment.

To carry out these views, a home has been opened by a society of ladies in a neatly furnished house at No. 220 North 13th Street, Philadelphia, designed exclusively for the class mentioned. The passer-by only sees what is apparently a private dwelling; but within are all the appointments of a small, well-ordered public institution, having its Matron, Board of Managers, etc. Privacy is the order of the house; and the inmates, it is hoped, will be secured through the medical profession, and their friends or relatives. Although in these cases moral restraint is generally required rather than medical treatment, yet the latter, when necessary, will be here administered under the supervision of Dr. Robert P. Harris.

OBITUARY RECORD.—At Philadelphia, on April 12, JONATHAN M. FOLTZ, M.D., late Surgeon-General U. S. N., aged 67 years.

Dr. Foltz was born in Lancaster County, Pennsylvania, and studied medicine at Jefferson Medical College, in this city, where he graduated in 1830. He was commissioned assistant surgeon in the navy April 4, 1831, and was ordered to the frigate *Potomac*, in which vessel he made a voyage around the world. He served on various American ships of war, and was surgeon on the fleet sent to the Gulf of Mexico during the war with Mexico. During the rebellion, he served on the frigate *Santee*, and was under Admiral Farragut in all his operations on the Mississippi River and at Mobile. He was a member of the Board of Medical Examiners, from 1864 to 1867. In 1870, he was made President of the Naval Medical Board. In 1871, he was appointed Chief of the Bureau of Medicine and Surgery, with the rank of Commodore, and was retired in 1872, after forty-two years of active service.

FOREIGN INTELLIGENCE.

Treatment of Ovarian Hysteria.—The correspondent of the *Lancet* in describing a visit to the Hospice de la Salpêtrière

makes the following report of Prof. Charcot's treatment of hysteria:—

We had the opportunity of seeing Dr. Charcot apply his method of stopping a fit instantaneously in women affected with "ovarian hysteria." Two women fell into a fit, and Dr. Charcot by applying pressure with the hands to the diseased ovary arrested the paroxysm almost immediately.

Dr. Bourneville, who accompanied me on my visit, spoke of the various new substances which he is now trying under the direction of Dr. Charcot in cases of nervous disease, and especially of nitrite of amyl, bromide of camphor, bromide of sodium, and bromide of zinc. He is still very well satisfied with the effects of bromide of camphor since his first researches on the drug. It is administered largely at La Salpêtrière, in the form either of Clin's capsules or of enemata. In a great number of epileptic cases it has been found to diminish the vertigo most notably, and to diminish in a good many cases the number of fits. It has rendered considerable service in the delirium which follows the fits in epileptic mania, and has proved very useful in hysteria. I have been promised Dr. Bourneville's observations on the other drugs I have mentioned. I cannot conclude, however, without remarking that the hydropathic and bathing arrangements of such a large and special establishment as La Salpêtrière seem scanty and insufficient. This part of the hospital arrangements is so very important in the treatment of nervous affections that it is strange that the Assistance Publique does not understand the good, and even the saving, that would result from greater liberality in the supply of baths.—*Lancet*, April 14, 1877.

Administering Iodine through a Nurse.—Dr. GEMMEL, of Birnbaum, relates (*Berlin. Klin. Woch.*, April 9) the case of a feeble, rickety child a year and eight months old, to whom it was thought of great importance that iodine should be administered, which, however, in any form tried, had induced vomiting and irregular action of the bowels. It was then resolved to try giving it through the milk of a

nurse, and in a few days after she had begun taking it her milk was sufficiently impregnated with it. It was found also that a cow's milk could be similarly affected by giving the animal ten grammes of iodide of potassium per diem for a fortnight. The child under the use of the nurse's milk bore the iodide very well and soon recovered.—*Med. Times and Gaz.*, April 28, 1877.

Death during Anæsthesia.—Anæsthesia was induced in a female, aged 21, who was to undergo amputation of the leg at Westminster Hospital, London. Chloroform to the extent of two drachms was given on lint, and the patient quietly and quickly became insensible; then ether, poured upon a sponge placed in a felt cone, was substituted for the chloroform. Meanwhile, Esmarch's bandage had been applied to the limb above the gangrenous part, and the band secured at the lower part of the thigh. The patient then became blue in the face and pulseless at the wrist; the lips were white, and the heart's action could not be felt. Artificial respiration was immediately begun, and the bandage and band were removed from the limb. In spite, however, of all attempts at resuscitation, which were continued for fifty minutes and which included cold affusion, slipping with towels, and the application of the interrupted current to the præcordium, the heart failed to beat again. The pupils were equally contracted throughout these attempts. The amount of ether used was two ounces, and the patient was moribund in about two minutes after the ether was begun. The chloroform was given by itself for about three or four minutes, and ether by itself for about two or three minutes. At the *post-mortem* examination, the surface of the heart showed friction-patches, but no signs of pericarditis. The wall of the right ventricle was very thin; that of the left side was thicker than usual, pale in colour, but not unusually soft. The mitral valves were much thickened, the chordæ tendinæ thickened, and the muscoli papillares hypertrophied. At the junction of the anterior cusp of the mitral valve with the wall of the ventricle

was an irregular ulcerated patch about as large as a silver sixpenny-piece, to which small masses of lymph were adherent. The aortic valves were thickened, but acted efficiently. Two large decolorized clots were found in the left ventricle.—*British Medical Journal*, March 31, 1877.

Daltonism and Navigation.—In the *Lyon Médical* for January 21, Dr. FAVRE, who is well known as an authority on colour-blindness, urges the necessity for a systematic examination of sailors in that respect. After much inquiry, he has found that the subject has been hitherto overlooked, and, with others who are favourably placed for judging, he agrees in the opinion that many of the disastrous collisions at sea, which occur principally at night, are due to a false perception of the colours of the lights used as signals.

Dr. Favre quotes from a recent paper by M. Féris, in proof of the fact that colour-blindness exists among the sailors of the French navy. M. Féris examined 501 sailors at Lorient, and found that 47, or about 9.4 per cent., were wanting in the accurate perception of colour. He also examined 152 men on board the *Hamelin*, and found 18, or 11.83 per cent., affected. These were not all equally faulty, and M. Féris adopted a classification which may be a useful guide to future investigators. 1. Those who hesitated in distinguishing colours, of whom there were 5. 2. Those who confused slight shades of different colours, as pale blue for green, 2 in number. 3. Decidedly colour-blind; (a) confusing blue and violet, of whom there were 6; (b) confusing both blue and violet, and also red and green, of whom there were 4.

Dr. Favre concludes his paper with some very forcible remarks on the necessity which such results show for a systematic examination of the eyes of those following maritime occupations.—*London Med. Record*, March 15, 1877.

International Medical Congress, Geneva, 1877.—The International Medical Congress will be opened at Geneva, on the

9th of September, under the auspices of the Swiss Federal Council and of the Canton and City of Geneva; and will remain in session the entire week. It will be composed of delegates from medical societies, foreign and local. Members only will have the right to participate in the proceeding of the Congress. The sessions will be held at the University. The registration book will be opened on the 8th of September, from noon until 5 o'clock.

The Congress will meet daily, first in sections, and afterwards in general meeting. The conclusions of the sections on the subjects designated for discussion will be reported to the Congress in general meeting. The general meetings will be devoted to the reception of the reports from sections, and, if desired, to their discussion; and to conferences or to reading of communications upon subjects of general interest.

Delegates desiring to make communications upon subjects not on the programme are requested to notify the committee at least 15 days before the opening of the Congress. The time allotted to each speaker is twenty minutes. The French will be the language of the Congress, but members may speak in any language.

The following preliminary programme for the various sections gives the topics for discussion, with the names of the reporters thereon:—

Section I. *Medicine*.—1. Ulcerations of the Stomach. Prof. Lebert. 2. Parasitic Affections of the Skin. Dr. Hardy. 3. Etiology of Typhoid Fever. Dr. Bouchard. 4. Treatment of Fever by Baths. Dr. De Cévenille. 5. On the Different Tissues found in the Organism, Dr. Zahn. 6. Indications and Therapeutic Value of Tracheotomy in Croup. Dr. Revilliod. 7. Universal Pharmacopœia. Prof. Gilie.

Section II. *Surgery*.—1. Bloodless Method of Esmarch. Dr. Esmarch. 2. Influence of Wounds upon Pregnancy. Dr. Verneuil. 3. Treatment of Oœna. Dr. Rouge. 4. Results of Articular Resections. Dr. Ollier. 5. Galvano-cautery. Dr. Julliard. 6. Means of Trans-

portation for Wounded. 7. Urethral Fistula. Dr. Reverdin.

Section III. *Midwifery and Gynecology*.—1. Placental Souffle. Dr. Rapin. 2. Artificial Feeding of Infants in the First Year. Dr. Zweifel. 3. Anæsthesia during Labour. Dr. Piachaud. 4. On the Law of Growth of Infants in their First Year, and of the Physiological and Pathological Deviations. Dr. Odier. 5. Pseudo-membranous Dysmenorrhœa. Dr. Gautier.

Section IV. *Public Medicine*.—1. Influence of Alcoholism on Mental Diseases. Dr. Magnan. 2. Influence of Adulterations of Alcoholic Liquors upon the Health of those who make and consume them. Dr. Guillaume. 3. Questions in Medical Geography. Dr. Lombard. 4. Influence of Immigration from the Country to the Cities. Dr. Dunant.

Section V. *Biology*.—1. Physical Characters of the Electric Discharge of the Torpedo. Physiological Analogies of this Discharge with Muscular Contractions. Dr. Marey. 2. Cerebral Localization. Dr. Broadbent. 3. Cause of Sleep. Dr. Preyer. 4. The Entozoa of Man. Dr. Vogt. 5. Functions of the Spleen. Dr. Schiff. 6. Histology of the Ovum and rôle of the ZoospERM in Fecundation. Dr. Fol. 7. Physiological Antagonism. Dr. Prevost.

Section VI. *Ophthalmology, etc.*—1. Indications for the Enucleation of the Globe of the Eye in cases of Sympathetic Ophthalmia. Dr. Warlomont. 2. Etiology and Prophylaxis of Myopia. Dr. Haltenhoff. 3. What are the best Methods for determining the State of the Principal Functions of the Visual Organ? (a) acuteness of vision; (b) perception of colours; (c) refraction and accommodation; (d) visual field (indirect vision); (e) mobility of the eyes. Dr. Fol. 4. Tenotomy of the Tensor Tympani. Dr. Colladon.

During the Congress, there will be held an exposition of apparatus or new instruments used in medicine, surgery, physiology, etc.

All communications relative to the Congress should be addressed to the Secretary General, Dr. Prevost, 8 Rue Eynard, Geneva.

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